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MEDICAID MEMO

TO: All Providers and Managed Care Organizations (MCOs) Participating in the Virginia Medical Assistance Program

FROM: Cynthia B. Jones, Director
Department of Medical Assistance Services (DMAS)

MEMO: Special

DATE: 3/7/2014

SUBJECT: Implementation of the CMS - Affordable Care Act Provider Enrollment and Screening Requirements

This memo is the second in a series regarding the implementation of the new provider enrollment and screening regulations published by the Centers for Medicare and Medicaid Services (CMS). As mentioned in the July 31, 2013 Medicaid Memo, the Department of Medical Assistance Services (DMAS) will implement the provider enrollment and screening regulations in response to directives in the standards established by Section 6401(a) of the Affordable Care Act (ACA) in which CMS requires all state Medicaid agencies to implement the provider enrollment and screening provisions of the Affordable Care Act (42 CFR 455 Subpart E). These regulations were published in the Federal Register, Vol. 76, February 2, 2011, and were effective March 25, 2011.

The changes to our enrollment processes and procedures, required by these new regulations, are scheduled to be implemented March 28, 2014.

Initial and Ongoing Screening Requirements

All new providers applying to participate with Medicaid must now undergo a federally mandated comprehensive screening before their application for participation is approved or renewed by DMAS. Screening will also be performed by DMAS on a monthly basis for any provider who participates with Virginia Medicaid. A full screening will be conducted at the time of revalidation (see Revalidation section below). The required screening measures vary based on the federally mandated categorical risk level. Providers' categorical risk levels are defined as "limited", "moderate" or "high". **See Attachment A** for a description of risk categories.

Revalidation

All providers will be required to revalidate their enrollment at least every 5 years. The revalidation of all existing providers will take place on an incremental basis and will be accommodated via our web portal. The online process will be utilized to complete and submit revalidations, and will allow a provider the ability to track the status of their online revalidation.

Registration into the Virginia Medicaid web portal will be required to access and use the online enrollment and revalidation system. Information on how to register can be found below. If you are not currently registered online, you will need to register before completing a revalidation.

All existing providers enrolled in the Virginia Medicaid program will be notified in writing of their revalidation date and informed of their new provider screening requirements in the revalidation notice. If you are currently

enrolled as a Medicare provider, DMAS may rely on the enrollment and screening facilitated by CMS to satisfy our provider screening requirements.

Ordering, Referring, and Prescribing (ORP) Providers

The Code of Federal Regulations 455:410(b) states that State Medicaid agencies must require all ordering or referring physicians or other professionals providing services under the State plan or under a waiver of the plan to be enrolled as participating providers.

The ACA requires ORP providers to enroll only to meet new ACA program integrity requirements designed to ensure all orders, prescriptions or referrals for items or services for Medicaid beneficiaries originate from appropriately licensed practitioners who have not been excluded from Medicare or Medicaid. **The only exception to this requirement is if a physician is ordering or referring services for a Medicaid Member in a risk-based managed care plan, the provider enrollment requirements are not applicable to that ordering or referring physician.**

If you are a provider who does not participate with Virginia Medicaid currently, but may order, refer or prescribe to Medicaid members, you must now be enrolled to ensure claims will be paid to the servicing provider who is billing for the service.

As a servicing provider, it is essential you include the National Provider Identifier (NPI) of any ORP provider on your claims to ensure the timely adjudication of your claims.

DMAS has created a streamlined enrollment application for all ORP providers to complete for enrollment. This streamlined enrollment application will be available on the web portal to all registered providers as part of the new online enrollment process. Please see the details below on how to become a registered provider in order to access this system.

New Billing Requirements and Edits

To ensure that DMAS is meeting the mandated requirements from CMS, new edits related to the ORP providers have been created. DMAS has established these new claim edits to ensure that all ORP and Attending provider NPI's are submitted on claims and that the NPI listed is actively enrolled for the date(s) of service in the Virginia Medicaid program. These new edits with be set to provide a explanation of benefits (EOB) message for any claims received from April 1 thru June 30, 2014. Effective July 1, 2014, any claims submitted with invalid data will begin to deny the claim.

The new edits are:

DMAS Edit/ESC	Description	HIPAA Codes	Resol/Action Effective 04/01/2014	Resol/Action Effective 06/28/2014	Comments
0191	Provider Referral Required	CO/207/N286	EOB	Denial	This edit will validate that the ORP's NPI is enrolled in DMAS. Refer to the Attachment A for providers required to have referral.

0194	Attending Provider Not on File	CO/16/N253	EOB	Denial	This edit will validate that the attending NPI is valid and actively enrolled in DMAS. Attending Provider NPI must be on all UB/837I/DDE institutional claims.
0195	Referring Provider Not on File	CO/207/N286	EOB	Denial	This edit will validate the referring NPI is valid and actively enrolled in DMAS
0196	Referring Provider Not Eligible on Date of Service	CO/207/N286	EOB	Denial	This edit will set if the Referring NPI is not enrolled and active for the dates of service on the claim.
0197	Attending Provider Required	CO/16/N253	EOB	Denial	This edit will set if the Attending NPI on claim is missing.
0198	Attending Provider Same as Billing Provider	CO/16/N253	EOB	Denial	This edit is checking to ensure the Attending NPI on the intuitional claim is not the billing provider. The Institution is expected to be the billing provider.
0199	Attending Provider Not Eligible on Date of Service	CO/16/N253	EOB	Denial	This edit will validate that the attending NPI is valid and actively enrolled in DMAS for the dates of service(s) on claim. Attending Provider NPI must be on all UB/837I/DDE institutional claims.

Impact of Edits for ORP Providers on Pharmacy Claims

Provisions of the Affordable Care Act require that all practitioners who prescribe medications for Virginia Medicaid Members must be enrolled with Virginia Medicaid. This means that any practitioner not currently enrolled must do so in order to continue to order, prescribe or refer services. Effective March 28, 2014, a message will be returned to the pharmacy (via point-of-service) stating that the prescriber is not an enrolled Medicaid provider (DMAS Edit 1500 or NCPDP Edit 56). After 60 days, pharmacy claims will deny if the provider has not enrolled with Virginia Medicaid. Failure of providers to enroll will impact Members' ability to obtain their medication.

Application Fees

All newly enrolling (including new locations), re-enrolling, and reactivating institutional providers are required to pay an application fee. The fee requirement only applies to hospitals, hospice, nursing facilities, outpatient rehabilitation facilities, rural health clinics, federally qualified health centers, home health agencies, durable medical equipment providers, prosthetic/orthotic providers, independent labs, renal unit/renal dialysis clinics, residential psychiatric treatment facilities, emergency/air ambulance, emergency ambulance, and various other institutional provider types (**See Attachment B for Provider Types**). If your provider type is required to pay an application fee, it will be outlined in the Virginia Medicaid web portal.

The Centers for Medicare and Medicaid Services (CMS) determines what the application fee is each year. The application fee for fiscal year 2014 is $542. This fee is not required to be paid to Virginia Medicaid if the provider has already paid the fee to another state Medicaid program or Medicare, or has been granted a hardship exemption by Medicare. Virginia Medicaid is required to obtain proof of previous payment or exemption before the application or revalidation can be processed, or participation can commence. Documentation of previous payments or exemption will be requested during enrollment or re-enrollment. Fees may be paid by check or credit card, and payment instructions are included on the web portal.

Newly Enrolling Providers & Provider Profile Maintenance

Newly enrolling providers are encouraged to utilize our new on-line enrollment process through the web portal. Through this enhanced process, providers will be able to submit everything necessary for their enrollment to be processed, upload and attach necessary documentation, pay application fees (where applicable) and find out the status of their enrollment application. Subsequently, the same portal will be utilized for updating changes in ownership, demographic information and to perform federally mandated 5 year revalidations.

Provider Enrollment Applications Process

After the implementation of the provider screening regulations, providers who wish to participate with Virginia Medicaid will be directed to complete electronic enrollments through our web portal. If a provider is unable to enroll electronically through the web, they can download a paper application and follow the instructions for submission with the form. We strongly encourage providers to enroll via our web portal once it is implemented. An application for participation submitted on paper will add additional time to the processing of your enrollment.

If a provider is utilizing the paper enrollment application as a means to request enrollment in Virginia Medicaid, they are required to complete and submit the new applications that will be posted on the Virginia Medicaid web portal. Any previous versions of the provider enrollment application will be obsolete as of the date of this implementation. If a provider submits an obsolete provider enrollment application it will be rejected with a request for the provider to utilize the online enrollment process, or download and submit the new application.

First Time Registrations to the new Virginia Medicaid Web Portal

In order to gain access to the new online enrollment, revalidation enhancements, and to provider profile maintenance, you must be registered in the Virginia Medicaid web portal. If you have not already registered for access to the Virginia Medicaid web portal, you may do so by visiting the site at www.virginiamedicaid.dmas.virginia.gov and establishing a user ID and password. By registering, you are acknowledging that you are the staff member who will have administrative rights for your organization. If you have any questions regarding the registration process, please refer to the Web registration reference materials

available on the web portal. If you need further assistance, please contact the Xerox Web Registration Support Call Center, toll free at 1-866-352-0496, from 8:00 A.M. to 5:00 P.M. Monday through Friday, except holidays.

"HELPLINE"

The "HELPLINE" is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays. The "HELPLINE" numbers are:

1-804-786-6273	Richmond area and out-of-state long distance
1-800-552-8627	All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.

Attached Number of Pages: (3)

Attachment A: Federally Mandated Categorical Risk Levels

Limited Risk Screening Requirements

Limited risk provider types are physician or non-physician practitioners and medical groups or clinics; ambulatory surgical centers; renal facilities; federally qualified health centers; laboratories; hospitals, portable x-ray suppliers; rural health clinics; radiation therapy centers, and skilled nursing facilities. The following screening requirements will apply to a limited risk provider: (1) Verification that a provider or supplier meets any applicable Federal regulations, or State requirements for the provider or supplier type prior to making an enrollment determination; (2) verification that a provider or supplier meets applicable licensure requirements; and (3) federal and state database checks on a pre- and post-enrollment basis to ensure that providers and suppliers continue to meet the enrollment criteria for their provider/supplier type and that they are not excluded from providing services in federally funded programs.

Moderate Risk Screening Requirements

Moderate risk provider types are community mental health centers; comprehensive outpatient rehabilitation facilities; hospice organizations; independent diagnostic testing facilities; independent clinical laboratories; ambulance services suppliers and suppliers of prosthetics and orthotics. The following screening requirements will apply to a moderate risk provider: Unannounced pre-and/or post-enrollment site visits in addition to those screening requirements applicable to the limited risk provider category listed above. The screening requirements listed in this section are to be performed at the time of initial enrollment and at the time of revalidation, which is at least every 5 years.

High Risk Screening Requirements

High risk provider types are home health agencies and suppliers of durable medical equipment. In addition to those screening requirements applicable to the limited and moderate risk provider categories listed above, providers in the high risk category may be required to undergo criminal background check(s) and submission of fingerprints. These requirements apply to owners, authorized or delegated officials or managing employees of any provider or supplier assigned to the “high” level of screening. At this time, DMAS is awaiting guidance from CMS on the implementation of criminal background checks. More information will be forthcoming in future Virginia Medicaid communications regarding the requirement for criminal background checks and submission of fingerprints. All newly enrolling (including new locations), re-enrolling, and reactivating institutional providers are required to pay an application fee.

Attachment B

Provider Type	Rule Risk Category	App Fee Requirement Yes(Y) or No(N)
Comprehensive Outpatient Rehab Facility (CORF)	Moderate	Y
Hospital	Limited	Y
Hospital Medical Surgery Mental Health and Mental Retarded	Limited	Y
Hospital Medical Surgery Mental Retarded	Limited	Y
Hospital TB	Limited	Y
Long Stay Hospital	Limited	Y
Long Stay Inpatient Hospital	Limited	Y
Private Mental Hospital(inpatient psych)	Limited	Y
Rehab Outpatient	Limited	Y
Rehabilitation Hospital	Limited	Y
Rehabilitation Hospital	Limited	Y
State Mental Hospital(Aged)	Limited	Y
State Mental Hospital(less than age 21)	Limited	Y
State Mental Hospital(Med-Surg)	Limited	Y
Audiologist	Limited	N
Baby Care	Limited	N
Certified Professional Midwife	Limited	N
Chiropractor	Limited	N
Clinical Nurse Specialist - Psychiatric Only	Limited	N
Clinical Psychologist	Limited	N
Licensed Clinical Social Worker	Limited	N
Licensed Marriage and Family Therapist	Limited	N
Licensed Professional Counselor	Limited	N
Licensed School Psychologist	Limited	N
Nurse Practitioner	Limited	N
Optician	Limited	N
Optometrist	Limited	N
Physician	Limited	N
Physician	Limited	N
Physician	Limited	N
Podiatrist	Limited	N
Psychiatrist	Limited	N
Psychiatrist	Limited	N
Substance Abuse Practitioner	Limited	N
Ambulance	Moderate	Y
Ambulance	Moderate	Y
Durable Medical Equipment (DME)	Moderate –Revalidating	Y
	High – Newly enrolling	
Emergency Air Ambulance	Moderate	Y
Emergency Air Ambulance	Moderate	Y
Hearing Aid	Limited	N
Home Health Agency - State Owned	Moderate –Revalidating	Y
	High – Newly enrolling	
Home Health Agency - Private Owned	Moderate –Revalidating	Y
	High – Newly enrolling	
Hospice	Moderate	Y
Independent Laboratory	Moderate	Y
Local Education Agency	Limited	N
Pharmacy	Limited	N
Prosthetic Services	Moderate –Revalidating	Y
	High – Newly enrolling	
Renal Unit	Limited	Y
Adult Day Health Care	Limited	N
Private Duty Nursing	Limited	N

Provider Type	Rule Risk Category	App Fee Requirement Yes(Y) or No(N)
Federally Qualified Health Center	Limited	Y
Health Department Clinic	Limited	N
Rural Health Clinic	Limited	Y
Developmental Disability Waiver	Limited	N
Alzheimer's Assisted Living Waiver	Limited	N
Treatment Foster Care Program	Limited	N
Qualified Medicare Beneficiary (QMB)	Limited	N
ICF-Mental Health	Limited	Y
ICF-MR Community Owned	Limited	Y
ICF-MR State Owned	Limited	Y
Intensive Care Facility	Limited	Y
Skilled Nursing Home	Limited	Y
SNF-Mental Health	Limited	Y
SNF-MR	Limited	Y
	Limited	Y
Consumer Directed Service Coordination	Limited	N
Personal Care	Limited	N
Respite Care	Limited	N
Personal Emergency Response System	Moderate –Revalidating	Y
	High – Newly enrolling	
Case Management DD Waiver	Limited	N
CMHP Transition Coordinator	Limited	N
Transition Coordinator	Limited	N
PACE	Limited	N
Family Caregiver Training	Limited	N
Intellectual Disabilities Waiver	Limited	N
Mental Health Services	Limited - all others	Y - only for Mental Health Clinics
	Moderate -- Community Mental Health Centers	
Early Intervention	Limited	N
Group Enrollment	Limited	N
Group Enrollment	Limited	N
Ambulatory Surgical Center	Limited	Y
Ordering, Referring, or Prescribing Provider	Limited	N